Cognitive-Behavioral Therapies for Trauma

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CHAPTER SIX

Cognitive Therapy for Trauma-Related Guilt

EDWARD S. KUBANY

There is widespread agreement among traumatologists that how trauma survivors intellectually process, judge, or assign meaning to the trauma is an important factor in posttrauma adjustment (Foa, Steketee, & Rothbaum, 1989; Kubany & Manke, 1995; Roth, Liebowitz, & DeRosa, 1997). The role of meaning in trauma has been studied under various labels, including survivor "appraisals," internal and external "attributions" (e.g., Andrews & Brewin, 1990), "maladaptive beliefs" (e.g., Resick & Schnicke, 1993), explanations "why" the trauma occurred (e.g., Frazier & Schauben, 1994), narrative "trauma themes" (Newman, Riggs, & Roth, 1997), "self-blame" (e.g., Miller & Porter, 1983), "behavioral and characterological" self-blame (e.g., Janoff-Bulman, 1985), "assimilation and accommodation" (Resick & Schnicke, 1993), "cognitive schemata" (Dutton, Burghardt, Perrin, Chrestman, & Halle, 1994), "pathogenic schemas" (Smucker & Niederee, 1995), and "errors of logic" and "faulty conclusions" (Kubany & Manke, 1995). Despite this diversity of labels, much of the research on the role of cognition in trauma has focused on survivors' phenomenology of their role in the trauma, much of which relates to guilt and self-blame.

Research reviewed elsewhere shows that trauma-related guilt is a common problem for survivors of many different kinds of traumatic events—including survivors of combat, physical and sexual abuse, technological disasters, and surviving family members of victims of accidents, suicide, homicide, and sudden illness (Kubany et al., 1995; Kubany & Manke, 1995). Our own research, using a recently validated Trauma-Related Guilt Inventory, documents that trauma-related guilt is pervasive both within and across survivor groups (Kubany et al., 1996; Kubany, Haynes, Owens, et al., 1997). In one series of studies, trauma-

related guilt was assessed in 74 Vietnam War veterans and 168 treatment-seeking battered women (Kubany et al., 1996). Nearly two-thirds of the veterans reported moderate or greater guilt related to trauma in Vietnam, and almost one-third reported guilt in the considerable to extreme range. Among the battered women, almost half reported moderate or greater guilt related to their abuse, and approximately one in four reported guilt in the considerable to extreme range. Only 6 of 168 women (4%) reported no abuse-related guilt. In a study of treatment-seeking female survivors of rape and incest, 54% of the incest survivors and 68% of the rape survivors reported moderate or greater guilt related to their victimization (Kubany, Haynes, Owens, et al., 1997).

TRAUMA-RELATED GUILT AND OTHER PSYCHOPATHOLOGY

Research by other investigators indicates that trauma-related guilt is correlated with depression and suicidal ideation among trauma survivors (see Kubany et al., 1995, and Kubany & Manke, 1995, for brief reviews). In our own research with Vietnam War veterans and battered women, trauma-related guilt has been highly positively correlated with posttraumatic stress disorder (PTSD), depression, negative self-esteem, shame, social anxiety and avoidance, and suicidal thoughts (Kubany et al., 1995; Kubany et al., 1996). We have also found significant positive relationships between cognitive aspects of guilt and psychopathology. In studies with 58 Vietnam War veterans and 50 battered women, measures of PTSD and depression were significantly correlated with multiple-choice items assessing beliefs about causal responsibility, justifiability of actions taken, wrongdoing, and preoutcome knowledge (Kubany et al., 1995). In another study with 74 Vietnam veterans and 68 battered women, scores on the Guilt Cognitions scale of the Trauma-Related Guilt Inventory were significantly correlated with measures of depression, PTSD, negative self-esteem, shame, social anxiety and avoidance, and suicidal ideation (Kubany et al., 1996).

Guilt was a core feature of PTSD in DSM-III, but was relegated to associated feature status in DSM-III-R and DSM-IV (American Psychiatric Association, 1994). One of the reasons for this diminished status is that in the DSM, PTSD-related guilt is restricted narrowly to concerns about *survival.* My colleagues and I have noted elsewhere that many important trauma-related guilt issues are unrelated to survival concerns (e.g., Kubany et al., 1996). In light of the pervasiveness and severity of guilt among trauma survivors, we believe that guilt should be considered to be a key feature of PTSD and will be a key feature again when DSM-V is introduced (e.g., Foa, 1993). Furthermore, although needing substantiation in controlled research, it has been my experience that guilt and guilt-related beliefs play an important causal role in the maintenance and perpetuation of posttraumatic stress, depression, and low self-esteem.

A GUIDING CONCEPTUALIZATION OF GUILT

There is widespread agreement that guilt has both affective and cognitive dimensions (Kubany, 1997a; Kubany et al., 1995). My colleagues and I have argued for a conceptualization of guilt in which cognitive elements play an extremely important role. We have identified four cognitive dimensions or components of guilt, which include (1) perceived responsibility for causing a negative outcome, (2) perceived lack of justification for actions taken, (3) perceived wrongdoing or violation of values, and (4) beliefs about preoutcome knowledge (e.g., Fischhoff, 1975; Kubany et al., 1995). Consistent with appraisal theories of emotion (e.g., Ellsworth, 1994), we have defined guilt as *an unpleasant feeling accompanied by a belief (or beliefs) that one should have thought, felt, or acted differently.* This definition has guided our theoretical work on guilt (e.g., Kubany, 1997a; Kubany et al., 1995), our guilt assessment research (e.g., Kubany et al., 1996), and our development of a cognitive therapy model, which is the topic of this chapter.

ERRONEOUS THINKING AMONG TRAUMA SURVIVORS

Faulty Conclusions and Trauma-Related Guilt

Several investigators have observed that many trauma survivors exaggerate or distort the importance of their roles in traumatic events and often experience guilt that has little or no rational basis (see Kubany & Manke, 1995). Kubany and Manke observed that trauma survivors tend to draw four kinds of faulty conclusions concerning their roles in trauma, each of which involves distortion of a cognitive component of guilt. First, many survivors believe they "knew" what was going to happen before it was possible to know, or that they dismissed or overlooked clues that "signaled" what was going to occur (*hindsight bias*; Fischhoff, 1975; Kubany & Manke, 1995). Second, many survivors believe that their trauma-related actions were less justified than would be concluded on the basis of an objective analysis of the facts (*justification distortion*). Third, many survivors accept an inordinate share of responsibility for causing the trauma or related negative outcomes (*responsibility distortion*). Fourth, many survivors believe they violated personal or moral convictions, even though their intentions and actions were consistent with their convictions (*wrongdoing distortion*).

Thinking Errors That Lead to Faulty Conclusions

Kubany and Manke (1995) identified 15 thinking errors that can lead trauma survivors to draw faulty conclusions related to the experience of guilt (also see Kubany, 1997b). Each of these thinking errors is briefly described here.

A Thinking Error That Causes Faulty Beliefs about Preoutcome Knowledge

(PK1) Hindsight-biased thinking. The term "hindsight bias" comes from social psychology and reflects the fact that outcome knowledge tends to bias people's recollections of what they actually knew before events occurred (Fischhoff, 1975; Hawkins & Hastie, 1990). Hindsight bias can lead survivors to conclude that there were signs or clues signaling what was going to happen when signs or clues did not exist or were never perceived; thus, many survivors remember themselves as "knowing" what they did not know. Hindsight-biased thinking is signaled by use of phrases such as, "I should have . . . I could have . . . I saw it coming . . . It was foreseeable." An example is in the following statements by grandparents who lost a grandchild to sudden infant death syndrome (SIDS): "I should have been able to detect a problem . . . I wondered if I could have prevented it" (De Frain, Jacub, & Mendoza, 1992, p. 170).

Seven Thinking Errors That Contribute to Faulty Conclusions about Justification

(J1) Failure to recognize that different decision-making "rules" apply when time is precious than in situations that allow extended contemplation of options. During many traumatic events (e.g., earthquakes, sexual assaults, ambushes during combat), time is precious, and split-second decision making, under extremely stressful conditions, is often required. The quality of decisions having life-and-death implications and made under the pressure of time should not be evaluated against the quality of decisions made after extended contemplation of alternatives.

(J2) Weighing the merits of actions taken against options that only came to mind later. In trying to understand "why" the trauma occurred, many survivors psychologically rehash or replay the trauma over and over. In so doing, they sometimes think of something they "could have" done to prevent or mitigate some tragic outcome—*had it occurred to them prior to or during the trauma.* It is a serious mistake when survivors evaluate their trauma-related actions against "options" that did not perceptually exist when the trauma occurred.

(J3) Weighing the merits of actions taken against ideal or fantasy options that did not exist. Some trauma survivors evaluate their actions during the trauma against idealized (but *unavailable*) "options" that "would have avoided the rape, prevented the beating, stopped the incest, or kept everyone safe and alive" (Kubany & Manke, 1995, p. 38). This thinking error is discussed in a case study later in this chapter of a formerly battered woman who felt guilty about not having left her abusive husband sooner.

(J4) Focusing only on "good" things that might have happened had an alternative action been taken. Sometimes, trauma-related actions that were contemplated but rejected look much better in retrospect than they did when they were

originally considered. For example, some rape victims focus on the possibility that they might have eluded the rape had they fought back and downplay or fail to remember the risks that would have been associated with fighting back. A combat veteran who experienced guilt about withdrawing from an ambush without a missing buddy assumed that he and his platoon could have stayed until they found their buddy *without risk* to everyone else's life (Kubany, 1997c, p. 229).

(J5) Tendency to overlook "benefits" associated with actions taken. Sometimes, trauma survivors validate important values by their trauma-related actions and fail to realize that these values would have been invalidated to some degree had other courses of action been chosen. A Vietnam War veteran who felt guilty about violating "personal, moral, and religious values by taking human lives" argued that he never should put himself in a situation where he would have to choose between killing and getting killed, and should have gone to Canada instead (Kubany, 1997c). In addition to the fact that he did not *know* what he was going to encounter in Vietnam, he also failed to recognize that several important values were validated by his decision to go. For example, he validated central beliefs about himself as a loyal, patriotic American committed to doing his share and serving his country.

(J6) Failure to compare available options in terms of their perceived probabilities of success before outcomes were known. Sometimes, knowledge of outcomes so colors survivors' perceptions about what they think they should have done during the trauma that they completely disregard or "forget" what they thought was likely to happen when they were deciding what to do. For example, during the Vietnam War, many excellent military decisions had adverse consequences because of the operation of unknown factors and chance. This does not mean that choices perceived as having a low probability of success (before outcomes were known) should have been selected.

(J7) Failure to realize that (a) acting on speculative hunches rarely pays off and (b) occurrence of a low probability event is not evidence that one should have "bet" on this outcome before it occurred. Some trauma survivors criticize themselves for not having acted on hunches, intuition, premonitions, or gut feelings—which, if acted upon, might have avoided or lessened the impact of the trauma. For example, a rape survivor recently said to me, "I had a feeling I shouldn't have gone to that party" (where she was assaulted) even though she had absolutely no prior evidence that going to the party posed a danger. People do not ordinarily act on highly speculative hunches, hypotheses, or superstitious thoughts because such ideas do not reliably predict what is going to happen.

Four Thinking Errors That Contribute to Faulty Conclusions about Causal Responsibility

(R1) Hindsight-biased thinking. Hindsight-biased thinking can also lead trauma survivors to conclude that they are to some extent responsible for causing

the trauma because they did not act to prevent an "avoidable" and "foreseeable" outcome. For example, a former client believed that she was completely responsible for exposing her 4-year-old daughter to the trauma of seeing an elephant go on a violent and lethal rampage during a circus performance. Her reasoning was that "I chose to go to the circus at the end of the circus run, when animals are probably tired; trainers are probably tired. Just irresponsible. I was trying to fit it into my schedule."

(R2) Obliviousness to the totality of forces that cause traumatic events. Many trauma survivors appear to be completely unaware of the myriad people, forces, or factors outside of themselves that contribute to the occurrence of traumatic events. For example, an incest survivor who was self-condemning about getting involved in prostitution at age 14 said that she, alone, was responsible for that "choice." This woman completely disregarded a multiplicity of external factors that may have contributed to "her" decision: (a) the incest that lowered her self-esteem and life expectations (e.g., "I'm already damaged goods; what difference does it make?"); (b) the lack of public education about prostitution and sexual abuse; (c) vulnerability associated with homelessness (she had run away to escape the incest); (d) lack of money and (e) lack of social support; (f) pimps; (g) organized crime; (h) inadequate police and judicial enforcement; (i) widespread availability of illicit drugs; and (j) a societal context in which women are sexualized and considered by many as the "less than" gender.

(R3) Equating a belief that one could have done something to prevent a traumatic event with a belief that one caused the event. Although completely illogical, many trauma survivors equate beliefs that they "could have prevented" some tragic outcome with beliefs that they "caused" the outcome. For example, a battered woman who thinks that she provoked or caused her abuse by "talking back" did *not* cause the bruises on her face.

(R4) Confusion between responsibility as accountability (e.g., one's "job") and responsibility as power to cause or control outcomes. Many people believe falsely that when they are given a job or "put in charge," they have complete causal responsibility for negative outcomes associated with that role. For example, just because a Vietnam War army platoon leader was in command, it does not mean that he had the power to keep all of his men alive. Similarly, many parents hold themselves responsible for serious misfortunes that befall their children even though they do not have the superhuman power to foresee and prevent every conceivable bad thing that could happen to their children (e.g., genetic diseases, unforeseeable accidents, random acts of violence; see Rando, 1986).

Three Thinking Errors That Contribute to Faulty Conclusions about Wrongdoing

(W1) Tendency to conclude wrongdoing on the basis of the outcome rather than on the basis of one's intentions (before the outcome was known). When tragic

events occur, some survivors believe they violated their values simply because something bad happened and they were there—*irrespective* of their intentions or inability to influence the outcome. Even when the outcome was unforeseeable and their actions were entirely consistent with their values, some survivors will believe they "should have done more." For example, many innocent incest and rape survivors think they did something "wrong" and feel "dirty," or "ashamed" "just because it happened" and because of religious teachings about purity and sexual behavior.

(W2) Failure to realize that strong emotional reactions are not under voluntary control (i.e., not a matter of choice or willpower). Some incest and rape survivors feel "betrayed" by their bodies for being paralyzed with fear or by experiencing sexual arousal during the abuse. Similarly, many combat veterans experience guilt for having had debilitating fear reactions during combat. They may believe they "should have been able to control" their emotions and conclude they violated values by virtue of their failure to adhere to (unattainable) personal standards or expectations. It is important for trauma survivors to know that strong positive and negative emotional reactions are not intellectual "choices." For example, none of the combat veterans wanted to be afraid, and if they had had "choice control" over their emotions, they would chosen *not* to have been afraid.

(W3) Failure to recognize that when all available options have negative outcomes, the least bad choice is a highly moral choice. In some traumatic situations, no good choices are available, and no matter what a victim chooses to do, something bad is going to happen. For example, sexual assault victims can fight back and risk being seriously hurt or killed, or they can submit. Faced with such situations, some survivors will believe they violated their values because they deliberately "chose" to cause or "allow" a negative outcome to occur (e.g., "I just lay there and let it happen"). Trauma survivors need to know that if all their choices had negative consequences, their "least bad" choice was a sound and moral choice.

A Thinking Error That Contributes to All of the Faulty Conclusions

Belief that affect associated with a thought or idea is evidence *that the idea is valid or correct.* The presence of this thinking error is usually signaled by the phrase "I feel" in statements about beliefs, such as "I *feel* responsible," "I *feel* that what I did was wrong," or "To think that I shouldn't feel guilty makes me *feel* like I'm trying to squirm out of something." Affect associated with an idea appears to give the idea a ring of "truth" or "untruth"; however, the intensity of feelings associated with an idea is *not* evidence of the accuracy of the idea. Moreover, when feelings are used as evidence for the accuracy of an idea, judgment and objectivity are often impaired. For example, one of the reasons why some battered women make choices that are not in their best interests (e.g.,

deciding to stay in or return to a lethal situation) is that their decisions are driven by their feelings instead of logic.

OVERVIEW OF COGNITIVE THERAPY FOR TRAUMA-RELATED GUILT

The goal of cognitive therapy for trauma-related guilt (CT-TRG) is to help clients achieve an objective and accurate appraisal of their roles in trauma. There are three phases in CT-TRG: (1) assessment, (2) guilt incident debriefings, and (3) CT-TRG proper, which involves separate, semistructured procedures for correcting thinking errors that lead to faulty conclusions associated with guilt. Figure 6.1 is a diagrammatic representation of procedures employed in CT-TRG and the order in which they are usually followed. The figure also shows at which stage during CT-TRG each of the thinking errors is most likely to be discussed. The main procedures used in CT-TRG are briefly discussed below. These procedures are described and illustrated in greater detail elsewhere (Kubany, 1997c; Kubany & Manke, 1995), and clinicians who are interested in using CT-TRG are encouraged to examine these other sources.

Guilt Assessment

Assessment is an integral part of the CT-TRG model. My colleagues and I use a structured interview and specially designed questionnaires (1) to identify idiosyncratic sources of trauma-related guilt, (2) to assess clients' faulty thinking patterns, and (3) to evaluate treatment efficacy.

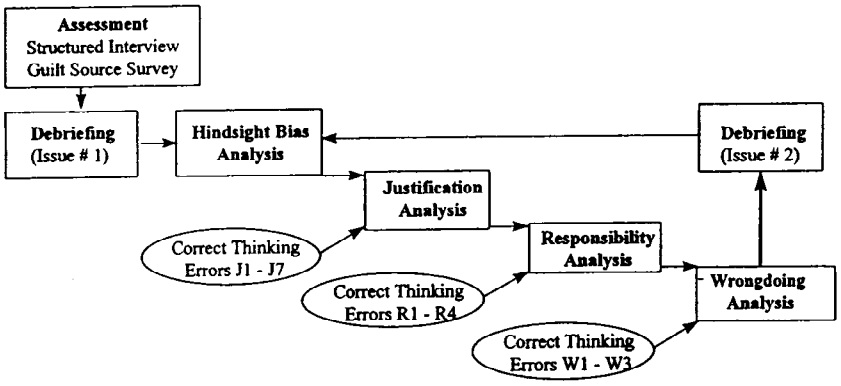

FIGURE 6.1. Procedures and order of procedures in cognitive therapy for trauma-related guilt (CT-TRG).

Sources of Guilt Assessment Interview

We have devised a structured interview to identify important guilt issues across five domains of guilt (Kubany & Manke, 1995). This interview (which also includes follow-up probes) consists of five core questions about the trauma that ask whether respondents feel guilty about (1) anything they *did,* (2) anything they *did not do,* (3) *thoughts or beliefs* they had that they now consider untrue, (4) *feelings* they *had,* and (5) *feelings* they *did not have.*

Sources of Trauma-Related Guilt Surveys

For our work with combat veterans, we have developed a survey that assesses 121 potential sources of guilt from the war zone (Kubany, Abueg, Kilauano, Manke, & Kaplan, 1997). After completing the survey, veteran clients are asked to circle four to six item numbers corresponding to events that are their most significant sources of guilt (e.g., "not being with your unit when casualties occurred"). These events then become treatment targets in CT-TRG.

We have also developed preliminary guilt source surveys for use with battered women (95 items so far), rape victims (80 items so far), and incest survivors (73 items so far) (see Kubany & Manke, 1995; available from Edward Kubany). All of the guilt source surveys can be used instead of, or in conjunction with, the Sources of Guilt Assessment Interview.

Attitudes About Guilt Survey

The Attitudes About Guilt Survey (AAGS; see Appendix) is used to assess the presence and magnitude of guilt components with respect to highly specific guilt issues (Kubany et al., 1995; Kubany & Manke, 1995). The first four items assess the magnitudes of each of the cognitive components of guilt. Clients are asked to fill out a separate AAGS for each guilt issue targeted for intervention, and before each guilt issue is analyzed, they are asked to explain their responses to the guilt cognition items. In addition to its value for initial assessment, the AAGS can be readministered as therapy proceeds to assess progress, lack of progress, or "slippage" (reversion to faulty logic that seemed to have been corrected) and the need for additional work.

Trauma-Related Guilt Inventory

The Trauma-Related Guilt Inventory (TRGI; Kubany et al., 1996) was constructed to assess guilt and cognitive and emotional aspects of guilt associated with specified traumatic events (e.g., combat, physical or sexual abuse). The TRGI includes three scales and three subscales. The scales include a Global Guilt Scale,

a Distress Scale, and a Guilt Cognitions Scale, which includes items that comprise the three subscales—Hindsight Bias/Responsibility, Wrongdoing, and Lack of Justification. The TRGI is meant to be used as a molar measure of trauma-related guilt (e.g., combat-related guilt, incest-related guilt) rather than as a measure of more specific guilt issues occurring within the context of the trauma (e.g., guilt about having been afraid or trading places with someone who got killed). The TRGI, which assesses 22 specific trauma-related beliefs, may have considerable utility as a treatment-outcome measure in CT-TRG and other cognitive-behavioral interventions aimed at modifying trauma survivors' beliefs about their role in trauma.

Guilt Incident Debriefings

Prior to CT-TRG proper (with *each* targeted guilt issue), a guilt incident debriefing is conducted. Clients are asked to give a detailed, nonevaluative description of exactly what happened during and immediately preceding the event in question. Clients are asked, "What did you see, hear, feel, and smell? Who did what, who said what, and what thoughts were going through your mind?" After clients describe what happened, they are asked, "What was the worst part of what happened," and what were their "feelings" and their "thoughts" during the worst part?

CT-TRG Proper

CT-TRG proper is a building block or "successive approximations" approach to the treatment of guilt in which guilt issues are addressed one at a time. With each issue, guilt is broken into its component parts, which are also treated one at a time—in isolation from the other components. CT-TRG proper includes considerable psychoeducation, particularly in the early stages of therapy. Much of what happens in later stages of CT-TRG is consistent with Beckian or traditional cognitive therapy (e.g., Beck, Rush, Shaw, & Emery, 1979). The therapist and client are actively involved in assessing the client's beliefs and considering alternative explanations. Much of this process is characterized by a Socratic line of inquiry, during which clients are asked many questions that challenge their logic and noncritical thinking.

After the initial incident debriefing exercise, the therapist discusses the meaning of guilt, its conceptualization as a multidimensional construct, and the various components of guilt. Clients are then given an overview of CT-TRG procedures and goals. They are told that they will be involved in an "intellectual analysis," the goal of which will be "to achieve an appraisal of your role in the trauma that can withstand rational analysis."

The process of correcting thinking errors associated with faulty conclusions

is conducted in the context of four semistructured procedures. These four procedures, which are outlined below, were designed to teach clients to distinguish what they knew "then" from what they know now and for analyzing and reappraising perceptions of justification, responsibility, and wrongdoing—in light of what they knew and believed when the trauma occurred.

1. *Probing for and correcting faulty conclusions about preoutcome knowledge (hindsight-bias analysis).* Efforts to correct faulty beliefs about preoutcome knowledge occurs in three overlapping phases or steps. First, clients are given an explanation of hindsight bias, accompanied by examples. The second step is to find out whether clients falsely believe they knew something prior to the trauma that "could have" enabled them to prevent or avoid a negative, trauma-related outcome. The third step is to help clients realize that it is *impossible* for knowledge acquired after an event to guide preoutcome decision making.

2. *Analyzing reasons for actions taken and dispelling faulty conclusions about justification.* Clients are first told that the best (or most justified) choice in *any* situation is the best choice among options actually considered. They are told that options that were ideal, but did not exist, and options that came to mind later should not be included in an analysis of justification. Second, clients are asked to detail their reasons for acting as they did. Third, they are asked what other courses of action they considered but rejected and to describe what they thought *at the time* would have happened had these courses been selected. Finally, clients are asked which choice—of options actually considered—was the most justified choice (knowing only what they knew then); when this is done, the course of action that was taken is almost always selected as the best choice.

3. *Assessing and analyzing external sources of causation and reappraising beliefs about causal responsibility.* There are four steps involved in helping clients achieve an objective assessment of their degree of responsibility for causing trauma-related outcomes. First, clients are made aware of the distinction between causation and blame. For example, the therapist may say, "Causation refers to 'what caused what' without any evaluation of whether what happened is good or bad. Blame implies wrongdoing as well as causation. We'll talk about wrongdoing a little later." Second, clients are assisted in generating a comprehensive listing of people and factors (outside of self) that contributed in some causal way to the outcome. Third, clients are asked to assign a percentage (of responsibility) to each external cause identified. Finally, clients are asked to reappraise their own causal contribution to the outcome.

4. *Correcting faulty conclusions about wrongdoing.* By the time the issue of wrongdoing is discussed, clients' beliefs about the degree to which they violated values are often mitigated in light of altered beliefs about preoutcome knowledge, justification, and responsibility. Clients are told that the label of wrongdoing is most commonly assigned when people intentionally cause harm or *knowingly* violate their values. Clients are asked whether they wanted the tragic outcome to

occur and whether they purposely made it happen. The answers to these questions are often "no," to which the therapist might say:

> "You didn't want it to happen and did not try to make it happen. In addition, you already concluded that there was no possible way that you could have known better, that what you did was the most justified choice, and that you were minimally responsible for causing what happened. How could what you did be wrong in any way?"

When clients experience guilt that stems from situations in which all courses of action had negative consequences, they are helped to realize that the least bad choice is a sound and moral choice.

Self-Monitoring Homework Assignments

Clients are routinely given self-monitoring homework assignments as a way of helping them stop saying or thinking certain kinds of maladaptive statements that may impede recovery from the effects of trauma. Clients are asked to keep track of three types of statements: (1) statements that include the words "should have," "could have," "if only," or "why"; (2) self-put-down statements; and (3) "I feel . . . " statements that end with words that are not emotions. Homework compliance is promoted by explaining to clients why these statements are maladaptive and why people are better off if they do not use them. They are told that the purpose of the self-monitoring assignment is to increase their awareness of when they make these statements (in thoughts and speech), which will make it easier to stop using them.

1. *Statements that include the words "should have," "could have," "if only," or "why."* Clients may be told that if they never say the words, "should have," "could have," "if only," or "why" ever again, they will be happier. They are told that use of these words and phrases suggest the presence of hindsight bias, which interferes with their ability to think clearly and objectively about their role in trauma. They are also informed that (a) there is evidence that use of "why" statements by trauma survivors is associated with poorer posttrauma adjustment (e.g., Frazier & Schauben, 1994), (b) finding out "why" is not going to make them feel better or change what happened (e.g., "is not going to bring your son back"), and (c) dwelling on "why" and rehashing what happened keeps them "stuck in the past."

2. *Self-put-down statements.* Many trauma survivors are self-deprecating and put themselves down in a variety of ways (e.g., "I'm stupid . . . weak . . . dirty . . . damaged goods . . . gullible . . . a nobody . . . an idiot . . . ugly"). Clients are told that the use of self-put-down statements is not going to make them feel better and is more likely to make them feel depressed and hopeless. The therapist might say:

"What if I said, 'I agree with you. You are stupid, and you're a total mess [self-labels the client used]'? Feel any better? Of course, not. Unfortunately, these words have the same negative effect on you when you say them to yourself as when someone else says them to you. *Nobody* deserves to be talked to that way. You need to start giving *yourself* the same respect that you want to get from others!"

3. *"I feel" statements that end with negative words that are not emotions.* When clients use the phrase, "I feel," with negative words that are not emotions, the feelings associated with the negative words make the statements *seem* more true. Clients are encouraged to use the phrase, "I feel," only with words that signify pure emotions such as happiness, sadness, anxiety, or "good mood" or "bad mood." They are encouraged to stop using the phrase, "I feel," in conjunction with words or phrases that are not emotions (e.g., [I feel] "sorry for him . . . responsible . . . like it's my fault . . . obligated . . . trapped . . . overwhelmed . . . emotionally alone . . . like damaged goods . . . like I'm stuck in a hole," etc.). Clients are told that merging such words with the phrase, "I feel," can produce confusion and impairs their ability to think objectively about themselves and their role in trauma (e.g., "Whether or not you violated your values can be best assessed at an intellectual level. What, if anything, did you do that you *think* was wrong?").

A specially designed self-monitoring form, which clients can use for recording occurrences of the three kinds of statements mentioned earlier is shown in Figure 6.2. Clients are instructed to record (in code, with numbers 1, 2, or 3) *only the first occurrence* of each type of statement *in the interval in which it is observed* to occur (e.g., between 7 and 8 A.M.). If a type of statement does not occur in an interval, nothing is recorded. The total number of observations (for each type of statement) for each day will be the total number out of 18 daily time intervals in which the statement was observed to occur (0 to 18). This type of interval recording procedure is much easier to use and elicits greater compliance than procedures that require clients to record *every* occurrence of a behavior being monitored.

CT-TRG WITH A FORMERLY BATTERED WOMAN

One case study will be described in detail to illustrate the main procedures in CT-TRG proper. The case is that of a middle-aged, formerly battered woman who had multiple sources of abuse-related guilt. The client, Angie, left an abusive family environment before she graduated from high school to marry a man who physically and sexually abused her for several years. Angie experienced guilt for getting involved in an abusive relationship ("out of the frying pan into the fire"), for not leaving the relationship when her children were small, and for not leaving

Person Observed: _____ Dates: From _____ To _____

Phrases of Concern: 1 = "I should have...could have...If only...Why..."
2 = "I *feel*..." (with words that are not emotions)
3 = Self-Put-Down Statements

Dates								Comments
	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.	
6 - 7am								
7 – 8								
8 – 9								
9 - 10								
10 - 11								
11 - 12								
12 - 1								
1 - 2								
2 - 3								
3 - 4								
4 - 5								
5 - 6								
6 - 7								
7 - 8								
8 - 9								
9 - 10								
10 - 11								
11 - 6am								
Total "1"s								
Total "2"s								
Total "3"s								

FIGURE 6.2. Self-monitoring recording form.

the relationship later without her children (her husband would have gotten custody). Later, out of the relationship, Angie experienced a resurgence of PTSD and depression symptomatology after finding out that her daughter was being battered by her own boyfriend and her son was involved in illicit drugs. These events exacerbated Angie's guilt for having "allowed" her children to witness domestic violence and for not leaving the relationship sooner. This therapy

segment illustrates the practice of CT-TRG proper, in which the main procedures are followed in their usual order—starting with an analysis of hindsight bias, followed by an analysis of justification for actions taken, and then by an analysis of causal responsibility. A wrongdoing analysis, per se, is not included in the segment, but was indirectly included in the other analyses.

In the initial debriefing, which lasted 1½ hours, Angie described in great detail how she had gotten involved with her husband, numerous incidents of abuse, and events leading up to her eventually leaving the relationship. I started CT-TRG proper with Angie by going over her responses on the AAGS about "choosing to get in the relationship and then not leaving." (The therapist–client interactions that follow are based on transcripts of actual therapy sessions.)

Hindsight-Bias Analysis

EK: Item 4 on the AAGS asks, "To what extent should you have known better and could have avoided or prevented the outcome?" This has to do with a concept called *hindsight bias.* It's the belief that we were smarter than we were capable of being when we made certain kinds of decisions, usually decisions with bad outcomes. We seem to think that somehow we could have known how it was going to turn out before it turned out.

A: It's like trying to be a genie.

EK: It's trying to be a person with a crystal ball.

A: I never thought of it that way. It's believing I knew how it was going to turn out before it happened.

EK: Before it happened. That you should have had the wisdom of making the right choice because you should have *somehow* known how it was going to turn out. As if you had information and data that you could draw on that you *did not actually have.*

A: I didn't.

EK: No you didn't. And I want you to know that hindsight bias isn't something that's reserved for crazy people or for trauma survivors. Hindsight bias has been demonstrated with college students in many studies.

A: Then I'm not the only one who does it.

EK: There's a general inclination for people to do it. I'll illustrate with a simple example, the kind of study that has been conducted many times [e.g., Fischhoff, 1975; Hawkins & Hastie, 1990]. Imagine an experiment in which three groups of subjects are asked to predict who is going to win the Super-

bowl based on statistics given to them about the teams, coaches, and players. The groups are then sequestered in a hotel, and on Monday, the experimenter asks them, "Which team do you think won, Buffalo or Dallas?" One group is "inadvertently" told that Dallas won. The second group is "inadvertently" told that Buffalo won, and the third group is not told who won. There are two interesting outcomes in these kinds of studies. One, if you're given information about the outcome, it's going to bias you in favor of that outcome.

A: So, the ones who were told Dallas won were more likely to predict Dallas.

EK: Right. And more importantly, when they're told that the outcome information biased their predictions, they deny it! They say, "No, no. That's what I would have predicted." And it's something trauma survivors do *all* the time. Now, you did not know 20 years ago what you know now. You knew you were in a hellish situation that you wanted to get away from. You had no idea that you were going to live with years of battering. You had no idea that your children were going to be having the kinds of problems they're having now.

A: Because if I knew, I wouldn't have married him.

EK: You wouldn't have married him.

A: If I knew, there is no way I would've married him.

EK: That's right.

During the previous session, I used an anecdote to illustrate the kind of distorted thinking that is common among trauma survivors. I told Angie about an army medic in Vietnam who unintentionally called a buddy into the line of fire and considered himself 100% responsible for his buddy's death (Kubany & Manke, 1995, p. 36). I make brief reference to this anecdote in my next comment to Angie, which illustrates how psychoeducation early in therapy can be briefly alluded to later to succinctly make an important point.

EK: If the medic I told you about last week had known he was going to be calling his buddy into the line of fire . . .

A: . . . he wouldn't have called him into the line of fire.

EK: But he somehow felt that he could have known. There is no possible way. If we could go back, and I was talking to you at that time [when she got married], you would be telling me all the reasons you thought your life was going to be better.

A: Yeah.

EK: Angie, I would suggest that, unless you know something that I don't know,

there is no possible way that you could have known better. One, it would have been impossible for you to tell me how it was going to turn out. And two, had you known, you wouldn't have done what you did.

A: No way, if I knew I was going to be treated like that.

EK: Why would anyone [intentionally] walk into a life like that?

A: Nobody would.

EK: You would have to be crazy, and you're not crazy.

A: Yeah. I wanted to get away from abuse [severe physical abuse from her mother].

EK: Of course. You were motivated to escape pain.

A: It's almost as if I'm punishing myself for nothing.

EK: You can say that again. It's almost as if you're punishing yourself for nothing.

A: Wow.

Justification Analysis

Ruling Out Idealized or Fantasy Choices That Did Not Exist

As we started to explore alternative courses of action that Angie contemplated when trapped in her abusive relationship, she dwelled on a course of action that was ideal but did not exist for her.

A: I thought about leaving when the children were small. I should have somehow gotten my resources together and left. Yeah. Somehow, I should have been able to make it. But, when I sit down, I cannot figure out that somehow. It's like, why wasn't I brave enough to pack up and leave? Why wasn't I the heroine? I used to daydream that I had packed up the kids and was gone to the mainland. And somehow, I had this little apartment, and we were going to make it—just like heroines do. You know? I don't know.

EK: Would you like me to give you an analogy to that?

A: Yeah.

EK: Here's a Vietnam soldier in a terrible situation where it's "kill or be killed." And he has this fantasy of himself on a desert island.

A: So they do the same thing?

EK: Sure. Or a fantasy that somehow, somehow, can't people see the absurdity of this?

A: Everybody wakes up, and nobody gets killed.

EK: Yeah. Let's deal with this like adults. Sometimes, this fantasy-like thinking has some value. But the danger in it is that, if we reify it, make it real, as if those are real options . . .

A: And that's what I did.

EK: It was not an option for that soldier to evaporate and be somewhere else. It was not an option for him to be the mediator and say, "Come on you guys, let's not fight. Let's not kill anyone. No one needs to die." The only options that were available were "kill or be killed." The only options were bad ones. Yes, you had the fantasy of what you would have liked to have happened, but that was not possible.

A: I didn't have any money.

EK: You didn't have any money.

A: I didn't have the money to buy tickets to go. And no resources. It's not like today where people help women get away.

EK: And it's almost as if [had you had gotten away], you would be totally insulated, with no way in the world that he could get to you. As if you had a bubble over your environment. Even if you could have gotten to the mainland, do you really think you would have been safe? Or felt safe? How many battered women have run away from their husbands, and then all of a sudden magically felt safe? What we're talking about here is catch-22.

A: You're damned if you do, and damned if you don't (*laughing*).

EK: You're damned if you do, and damned if you don't. The reason they experience guilt is that they weigh their alternatives against choices that were not actually available. Let me give you a classic example. This pair of marines in Vietnam had been inserted [by a helicopter] into enemy territory on a secret mission. And now they were trying to make a quick getaway with the enemy in pursuit. They were being hoisted out in harnesses by a hovering helicopter. The veteran's buddy got caught in a tree as they were trying to hoist him out. And the veteran [my client] was faced with the choice of either shooting his partner or allowing him to live and be tortured [with certainty] by the enemy. This man was also caught up with fantasy choices.

A: And he wasn't Rambo who could find a way to get him out (*laughing*).

EK: Yeah. That's right. And you wanted to see *yourself* as Superwoman.

A: I did!

EK: The veteran said, "I don't know what I could have done, but I should have been able to do *something*."

Comparison of Options When Angie Considered Leaving without the Children

EK: Okay, let's talk about what would have happened if you had left. What would have happened if you had chosen to leave?

A: Then the kids could have visited me. But when I look at that, they would have said that I abandoned them for my own stuff. Then they wouldn't have had any option on how to have been raised because they would have been raised by him. And his values would be the only ones they would ever see. They would never be nurtured emotionally. Now I'm so terrible because I stayed with Dad. But, I probably would have been terrible if I had left [and left them with Dad]. I couldn't win. It's that catch-22 again.

EK: Okay, what else would have happened if you had left?

A: Maybe something that wouldn't happen today but would have happened to a mother 20 years ago. A mother would have been scorned for leaving her children.

EK: So, you would have been subjected to public ridicule.

A: Yes, very much so. The other thing that I would have probably been subjected to is an ousting by the church. And that is a part that is ingrained in my personality or belief system. It's part of who I am—having a spiritual side.

EK: Okay, so you would have had to abandon that.

A: Yeah.

EK: You would have had to give that up—to say you don't really have a spiritual side. "I'm much too much materialistic." If you had decided to leave, and your life unfolded, and we were talking here today, do you think you would feel more guilty or less guilty now?

A: Probably more.

EK: Okay, let's look at your choices. You stayed. Of course, you didn't know what was going to happen because you had no crystal ball. On the other hand, if you had left, the children would not have been nurtured emotionally.

A: No.

EK: They would have been subjected to his sociopathic, narcissistic personality [Angie's characterization of her husband]—to rub off on them. So, any positive influence you could have had on the children would have been eliminated.

A: Totally. Plus, they would have been subject to physical abuse.

EK: That's right. They couldn't be protected.

A: No. Nobody to protect them.

EK: So, he could have mistreated them without any negative consequence whatsoever. And any possible regulation that your presence provided would have been eliminated.

A: Yeah.

EK: You would have been publicly scorned for leaving your children. Probably not only ousted by the church, but have to give up that spiritual side of yourself that you valued. "I've got to turn that in. I don't belong to that club anymore."

A: Yep.

EK: And you would have felt more guilty.

A: Yeah, when I look back at that.

EK: Now, did it make sense for you to have left under those circumstances? Doesn't it sound as if the potential consequences for leaving were worse than those for staying.

A: Yeah, *way more*!

Responsibility Analysis

When the justification analysis was completed, I helped Angie generate a list of all people and factors outside of herself that caused or contributed to her decision to remain in an abusive marriage. After several external sources of causation were identified, Angie was asked to assign a percentage of responsibility to each identified source (without being told that the total had to add up to [only] 100%).

EK: What share of the responsibility did your ex-husband have [for your staying in the relationship and continuing to get abused]? Scientifically, causally, how responsible was he?

A: Now I think more.

EK: More than what?

A: More than I did a few minutes ago.

EK: (*Laughs.*)

A: Strange. I really do. But, even for him I think 70%. How come I can't say 100?

EK: Well, you don't have to. Okay, let's take 70.

A: No. When you say "scientific," it sounds like more than 100%.

EK: Well then, what is it intellectually? This is a scientific question. This is a logic question. This is not an emotional question.

A: If it has nothing to do with emotion and is a scientific question, he's 100% responsible—because I never picked up the thing and hit myself.

EK: (*Laughs.*)

A: That's the bottom line. If you go scientific and [look at] what physically caused it, *he* did it.

EK: Okay. Now, let's go to the police. How much share of the responsibility did the police have for not protecting you and not getting you out of there?

A: Largely responsible. They never did arrest him. Even when he broke temporary restraining orders, he was never arrested. Never.

EK: So, how much responsibility did they share for the perpetuation of the abuse?

A: 100% too, because they kept causing it (*raised voice*)!

EK: So, maybe not in terms of the first time, but in the totality . . .

A: Yeah, because they kept letting him get away with it.

EK: That's right. They might have been able to stop it when they first became involved.

A: Oh yeah, because even when he broke the restraining order with John [her new boyfriend], when I started to date John, [the police dispatcher] kept saying, "They can't catch him. And too bad. They have to see him there."

EK: How about the courts?

A: Oh, the idiotic courts.

EK: How responsible were they for not stopping the abuse and allowing it to continue?

A: They too are another 100%, because of the stupid judges! The social worker was just as largely responsible also [for recommending that her husband be granted custody]. No way I'm gonna leave without my kids. No way I was gonna leave my children to somebody like him. And what about CPS [Child Protective Services]? They also copped out on me.

EK: How about the church or teachings of the church? Teaching you to be a martyr.

A: I don't think that's scientific responsibility.

EK: No, there is a scientific part of it. How much do the religious teachings of the church determine the actions of people in the community?

A: Religious beliefs make up maybe 80% of what we do.

EK: How responsible was your mother for your decision to stick it out?

A: Oh, she's got a large share because, number one, she said, "You can't get a divorce. He's a good provider."

EK: So, she's also giving you *that* propaganda.

A: Oh yeah. "He's a hard worker, and he does this and that." Oh she gave me 10 million reasons how great he was.

EK: I'm going to add up the percentages of everyone you counted, and I'm going to cut the percentages in half. (*Pause to add up the percentages.*) Adding it all up, it comes to 400%. And we haven't even gotten to *you* yet. (*Five-second pause.*) How responsible were *you*?

A: Oh my god. When you break it down, it's real different, isn't it?

EK: How could you have been 75% responsible?

A: I couldn't have.

EK: Not humanly possible.

A: There are so many things playing into it all at once, aren't there?

EK: Remember when I told you about the combat medic last week?

A: That's what I was thinking about. It feels like the soldier. (*Five-second pause.*) He was the one walking around with all the guilt, but he couldn't have stopped everyone else's behavior. I couldn't change the police. I couldn't change the courts. I couldn't teach that social worker. I couldn't help CPS to . . .

EK: You were a twig in a hurricane . . .

A: Oh my god.

EK: . . . that thinks you're responsible for the destruction of the community. You know what I would say? I would say that you were between "no way" and "slightly" responsible. That's what I would say.

A: Me too, now. I would say "slightly" now because I still made a choice.

EK: In a scientific sense, yes.

A: But I didn't make a choice to be abused although my body still had to be there. But, that's all. I did not cause the events that took place.

EK: That's exactly right. Just like the rape victim who says, "I was responsible for the rape because I went to the bar."

A: But there's no way. She might have gone to the bar 10 million times before and never got raped. I've got a lot to think about because of what we did today. I really do. I really do.

SPECIAL TOPIC: DISPUTING FEELINGS AS EVIDENCE FOR THE VALIDITY OF AN IDEA

Anticipation of relief for taking a contemplated course of action can sometimes cause battered women to make decisions that are not in their best interests. For example, one of the reasons that some battered women return to an abusive relationship is to obtain relief (reinforcement) from painful feelings associated with guilt. The following therapy segments are highlights from a session with a battered woman devoted entirely to dissuading her from using feelings as evidence of whether a contemplated decision was a good one. For this woman, anguish associated with her ex-boyfriend's pleadings to "come back," and anticipated relief if she "gave in" and went back, were being used as evidence that she "should go back."

The client, Fran, had been brutally beaten by her live-in boyfriend, Jimmy, on multiple occasions, and had been hospitalized with broken bones more than once. On *the day* Fran left her boyfriend and moved into a shelter for battered women, she had gone to the hospital emergency room more than once following separate incidents of abuse. Shortly before the session from which the therapy segment below was taken, Fran had received a phone call from her ex-boyfriend, pleading with her to come back. When this happened, she had been out of the relationship for almost a year.

F: Jimmy wouldn't take "No" for an answer. He said, "I want to get back together. I want to win you back." I said, "You're still using drugs," and he said, "Just once in awhile. I'll change to have you back. I'm not that bad, am I? I just want to be with you, and that's all I'm going to settle for." No matter how many times I told him "No," he started to cry and said, "I won't ever hit you again. Please. You've ripped my heart out." What really bothers me is what I'm feeling inside. Maybe I should go back and try again. And then I get scared at that feeling and look at everything I have now—my apartment, my car, my credit cards. I think of losing it all over again if I try.

EK: Fran, you've got to remember that you can't allow your feelings to serve as evidence for what decisions you make. When Jimmy says, "Please, please" and starts to cry, you feel bad.

F: I do.

EK: But the fact that you feel bad is not evidence that you should follow a certain course of action. In other words, whether or not it's in your best interests to go back cannot be determined by the intensity of your feelings when you think about going back. You're a very compassionate person, and you have a lot of empathy. And you want relief from feeling bad.

F: Yeah. . . . It just worries me, and he's had a rough time. . . . I don't think I would go back; but, to have those feelings inside . . .

EK: Once again, you're saying you have those feelings inside. You don't have "feelings *to go back.*" You have feelings, and you have thoughts.

F: Yeah.

EK: Don't merge them. . . . Don't use your feelings to guide your decisions. By the way, you have no control over the words that come out of Jimmy's mouth. Remember, words are only sound waves. You're acting like they're hitting you with the impact of huge hammers. They are just sound waves.

F: He knows all the buttons to push.

I explained to Fran that guilt induction can be a very effective way of *influencing* people who are easily made to feel guilty (which Fran definitely was). By "looking" sad or "acting" disappointed, or by sulking, someone can influence a person who has been taught to be guilt-prone to "give in" and do what the other person wants.

EK: Just because he says something doesn't mean it's true, or even that he believes what he's telling you! He is saying those words to influence you. When he says things like, "Please come back," what you want is relief, which is a very powerful reward. You want relief from the way those words make you feel, and going back would be one way to get relief from those feelings—however brief that relief might be.

F: Yeah.

EK: There is no genetic reason why his crying and saying "please" needs to evoke a bad feeling and thoughts that you should do what *he wants* you to do. . . . You need to be able to distinguish your thoughts from your feelings. And don't make decisions based on how you feel because your feelings may change. "I feel good. That means I should stay away. I feel bad. That means I should go back. I feel good. I should stay away." That's what leads to confusion. Neither those good feelings or bad feelings have *anything* to do with whether it's a good idea to stay away or not stay away! You have to remember that.

As the session was drawing to a close, I asked Fran how strongly she believed she would think and react in a specific desired way (which we had set as a goal) the next time Jimmy called.

EK: The next time Jimmy calls, and says something like, "Fran, I love you and miss you so much," how strongly will you believe the following statements: "You are 100% certain it's over. People couldn't drag you back. You might feel sad or bad for a little while, but you will experience zero guilt."

F: The way I'm feeling right at this moment?

EK: Did you hear yourself (*laughs*)? Fran, by saying, "the way I'm *feeling*," you're allowing feelings to interfere with your judgment about what is in your best interest. Rather than talk about what you "feel you should do," ask yourself, what decision is *in your best interests*?

F: I know it's a good idea to stay away.

Fran decided not to reconcile with her ex-boyfriend, and a few months later, she had a new job and was involved in a romantic relationship with a man who was treating her with respect.

SOME TREATMENT OBSTACLES AND SOLUTIONS

The CT-TRG model incorporates several features that address some of the potential obstacles to the effective treatment of guilt. These particular features, which are discussed below, were incorporated into the CT-TRG model precisely because of obstacles encountered during early efforts to help clients deal with or overcome their guilt.

The Need for Comprehensive Guilt Assessment and the Usual Necessity of Addressing More Than One Guilt Issue

The CT-TRG model emphasizes systematic and thorough assessment. Because many trauma survivors have multiple guilt issues—sometimes related to different traumas and sometimes related to multiple aspects of singular events—treatment of multiple issues may be necessary to effect global and generalized reductions in trauma-related guilt (e.g., Kubany, 1997c). For example, Kubany, Abueg, et al. (1997) suggest that incomplete trauma assessment may be one important reason why PTSD programs for combat veterans have not been very successful (e.g., Johnson et al., 1996). Noting that Vietnam War veterans in their samples reported more than 30 sources of (at least moderate) war-related guilt *on average*, Kubany, Abueg, et al. argue that it may often be necessary to treat multiple guilt issues over multiple sessions in order to produce clinically significant therapeutic benefits.

Comprehensive Trauma History Assessment

Obtaining a comprehensive assessment to lifetime exposure to trauma can sometimes be very important for uncovering all significant sources of trauma-related guilt (e.g., Kubany, Haynes, Leisen, et al., 1997). In fact, in some cases, treatment of guilt related to childhood or earlier traumatic events may be more important than or facilitate treatment related to more recent trauma. Two cases come

immediately to mind, and in both cases, the clients accepted an inordinate amount of responsibility for the welfare of others. In the first case, a Vietnam War veteran experienced overwhelming grief and crippling guilt over the death of a buddy, who was next to him when killed by an enemy sniper. This guilt issue was traced back to a "related" childhood event in which a friend died. Snorkeling at the beach, the client and his friend spotted a large school of fish. So, the client suggested that his friend get his fishing pole. On his way to get his pole, the friend fell off a rock jetty and drowned. Treatment of this guilt issue from childhood, which was more encapsulated and perhaps even more irrationally based than the Vietnam issue, seemed to accelerate the process of alleviating the veteran's guilt about the death of his buddy in Vietnam.

In a second case where assessment of lifetime trauma exposure to trauma was considered important, treatment of guilt linked to a childhood trauma seemed to help a formerly battered woman overcome a pervasive tendency to take responsibility for problems in her marriage and abuse by her husband. Even though this woman's presenting complaints revolved around partner abuse, our initial treatment focus was on guilt she experienced about childhood sexual abuse by her brother and a subsequent severe beating her brother received from their father. The theme linking these two sets of events was this woman's tendency to believe that it was her "job" to take care of, protect, and accept responsibility for adverse consequences to anyone with whom she had a close relationship.

The Need to Break Guilt Down into Its Component Parts and Treat One Part at a Time

In its early stages of development, the CT-TRG model did not include an explicit educational component, and distortions of the cognitive components of guilt were not addressed separately, in a stepwise and systematic manner. Cognitive distortions were addressed unsystematically in a piecemeal fashion. When conducting cognitive therapy in this way, I often observed glimpses of insight (e.g., "I never looked at it that way before"), emotional catharses, and expressions of relief at the end of the session. However, by the next session, I also observed frequently that clients had "slipped" back into their old thinking patterns, without appreciable reductions in their original levels of guilt. In the present CT-TRG format, breaking guilt down into its component parts, labeling separate thinking errors, and analyzing the guilt components one at a time seem to facilitate clients' ability to understand their faulty thinking patterns, to understand "why" they were drawing faulty conclusions, and to generalize this understanding to other guilt issues. For example, several CT-TRG clients have commented that they have learned skills or been given "tools" that enable them to understand and work on guilt issues on their own (e.g., Kubany, 1997c).

The Need to Obtain a Detailed Description of the Trauma to Facilitate Expression of Grief or Loss and to Identify Nonobvious Instances of Faulty Logic

As noted by Kubany and Manke (1995), clients' detailed, descriptive retelling of exactly what happened during the trauma can serve as a critical incident stress debriefing (Mitchell & Bray, 1990) that many clients have never had. When clients reexperience their trauma in this way, they often express strong negative affect, such as tearful grieving, and in this respect, the guilt incident debriefing serves as a form of direct exposure that can relieve negative affect associated with the trauma. At the same time, a client's detailed descriptions of events that are sources of guilt can provide invaluable assessment information about distortions in logic.

I partially attribute some of my therapy "failures" in the past to not urging clients to describe their traumatic experiences in great detail. One client whom I did not help much had been deeply in love and was engaged to be married when his fiancée was murdered while on a personal business trip overseas. This man had a demeanor of complete emotional detachment, and he spoke with noticeably flat affect. He came to therapy on the insistence of friends who said he had "changed" since his fiancée's death. When I asked him to tell me about the circumstances surrounding his fiancée's death, he superficially described what happened, and I did not press him to elaborate. After a few sessions, I was at a loss as to how to proceed, and the client dropped out of therapy. In retrospect, I believe that, had I conducted an extensive debriefing of events surrounding the fiancée's death, I might have uncovered important guilt (and anger) issues and also enabled my client to grieve his great loss.

I did not make a similar mistake with Mary, who sought therapy because of an abusive intimate relationship. During our third session, Mary mentioned that she was nearing the first anniversary of the suicide of her much younger brother, with whom she had been very close. I asked her what happened, and she responded, "In a nutshell, he hung himself." I then said, "Tell me—not in a nutshell. Tell me exactly what happened, in detail, and the events that led up to it." For the next several minutes, Mary described—with flat affect—several interactions with her brother, including the last time she saw him alive, when he seemed forlorn and sad. She said, "I asked him, 'What's wrong Tom,' and he said, 'Nothing. I just have a lot on my mind.' " Then, she recalled her brother during happier times. "He was such a happy guy. We went to parties. He was the life of the party. I was dancing next to him, having fun, acting crazy. But when I go to the same parties, it's not the same because my brother isn't there to laugh and have fun and have a good time."

At this point, Mary broke down and cried nonstop for 7 minutes. During these 7 minutes, I continued to conduct therapy, and Mary talked through her tears.

M: I wish he had talked to me—said something so we might have been able to help him.

EK: Had he been capable of telling you.

M: I really wish I pressed harder on that last day I saw him. I wish I had said more. Maybe he would not have died if he felt that somebody could help him.

EK: You *did not know* he was going to kill himself. If you had known he was so desperate, you would have done more.

M: I know that.

EK: You *did not know* that he was going to kill himself.

By the end of this session, Mary was reminiscing positively about her brother. In addition, she reported during subsequent sessions that she was now able to recall the good times with her brother without getting depressed and had no residual guilt regarding his suicide.

Dislodging Hindsight Bias When Clients Insist They "Knew" What Was Going to Happen

It can sometimes be difficult to dislodge hindsight-biased thinking when clients *insist* that they "knew" what was going to happen, especially if they actually entertained or contemplated options that "would have" prevented a traumatic outcome. Under such circumstances, it may be advisable to probe for further details about exactly what happened and determine when the client first knew *with certainty* what was going to happen.

One young woman with whom I worked experienced medical complications on three separate occasions following treatments by her family physician. After the third complication, she almost bled to death, and was left with a permanent disability. This woman experienced guilt about not having switched to another doctor. She said, "I had all the signs and signals that he wasn't a good doctor, and I stayed with him. My life would be profoundly different if I had listened to myself. I should have followed my hunches and got someone else." In probing for hindsight bias, it was clear that this client did not know that the doctor was not taking good care of her until after she almost died. However, she steadfastly maintained that she "knew" she should have switched. I kept asking "*when* did you have first *know* this?" She finally said that she "knew" after the second complication when she had "doubts" (but only doubts as it turned out) about her doctor's competence and actually did consider switching physicians at that time. She told me that she confronted her physician about the quality of care she was receiving, and he took her concerns so lightly that he convinced her that she was worrying for nothing, and "I believed him that nothing was wrong with me." My

client then realized that "it didn't make sense" to switch from a doctor who, despite his aloof demeanor, knew her so well, had all her medical records, and whom she believed at the time to be competent.

There is a simple and straightforward Socratic technique that can sometimes effectively dislodge clients' false beliefs that they had knowledge or definitive clues that a tragic outcome was going to occur before it was possible to know. Basically, this technique involves asking clients if they *actually* possessed knowledge that the trauma was going to occur, wouldn't they have done something about it? When clients answer affirmatively, the therapist can respond, "Isn't that proof you didn't know?" For example, a combat veteran who experienced guilt about not saving the life of a friend who was killed by friendly fire (Kubany, 1996) was asked, "If you knew your friend was in danger of being fired on by his own people, don't you think you would have done something about it?"

VET: Of course.

EK: Therefore, isn't that evidence that you had no idea of what the appropriate action was—that you didn't know what was going on?

VET: (*Nods yes.*)

EK: If you *knew* what was about to occur . . .

VET: I would have stopped it.

EK: You would have stopped it, which is evidence that you did *not* know. You found out later—and then you started imagining how you could have known or understand now what you should have done. Because of the outcome, it's *obvious.*

VET: Yeah.

Addressing Guilt of Clients Who Were Attracted to an Abuser Prior to the Abuse (the "Two Movie" Scenario)

Some battered women and many survivors of acquaintance or date rape experience guilt for having liked or been attracted to someone who subsequently abused or assaulted them. A detailed debriefing, starting with when the client first met or went out with the abuser, until the abuse occurred or started, may be indicated in such cases. A good example of this involved a teenage survivor of physical and sexual abuse with whom I worked in another country. Felice had run away from home because of her mother's overrestrictiveness and, while homeless, got involved with drugs. Wanting to escape this lifestyle, and upon the recommendation of her older sister, she went to stay with an older man who subsequently beat her up, raped her, and held her captive. Felice experienced guilt about having been "infatuated" with this man "because I should have known that he was going to

hurt me." The following therapy segment occurred after Felice spent 10 minutes describing how she met her abuser, why she liked him, how things changed, and the sequence of events that ended in her getting abused.

EK: When you first met and stayed with him, didn't he seem like a nice guy?

F: Yes.

EK: It didn't seem as if he had the potential to hurt you. You were infatuated with a nice man who treated you well. You saw him as protecting you and helping you get out of a bad life. You enjoyed his company. He was a handsome man. He liked the same kinds of things that you did (e.g., contemporary music). Why not like someone like that? You're remembering yourself as smarter than you actually were. But now, looking back, you think you should have seen some signs. You shouldn't have been so trusting. Looking back, it seems like there were big signals. Flashing red lights. You see, it was really like two different movies. The first movie ended just before he started comparing himself to God. [This was when Felice first got scared and started questioning the man's intentions. Shortly thereafter, he hit her with a broomstick and raped her.] And then, it turned into a horror story. So, the movie theater has two movies. First, it has a love story, and then it has a story about violence. Two different movies. Let me tell you about a similar situation with a woman I am still working with. She was raped by someone she dated. He had been courting her, and on this one occasion they were kissing, and she was getting physically aroused. Then, he started to rape her. And she felt guilty about liking him and getting aroused. It's the same story as yours. Two movies! She did not have the slightest idea that he would abuse her before he abused her. It was inconceivable to her that he would do anything like that. He had been a nice guy, and she was doing something that was consistent with her values by liking him and kissing him. And then, all of a sudden, he took off his mask and started acting like a demon. She had no idea he was going to do that prior to that moment. When she was aroused, she was aroused to a different guy. A different movie. Can you see how that situation is similar to yours.

F: Yes, I can.

(The above interaction also indicates how giving anecdotes about other trauma survivors—who faced situations similar to those faced by the client—may help clients perceive their own situation differently and more clearly.)

Although the "two-movie" analysis seems to apply most often when survivors had positive feelings toward someone who subsequently betrayed and abused them, this analysis is occasionally appropriate in work with survivors of other

traumatic events. For example, in Kubany (1997c) I described CT-TRG with a Vietnam War veteran who experienced guilt about firing in the direction of the enemy (because of the possible presence of "friendly forces") and also experienced guilt about not continuing to fire. "A damned-if-you-do and damned-if-you-don't situation, if I ever saw one," the veteran said (p. 233). Prior to our debriefing of this event, he never realized that his first decision (to fire) was based on a different set of "facts" than his second decision (to stop firing).

Getting Sidetracked or Off-Task

Guilt is only one of many problems experienced by trauma survivors, and in the "real world" of therapy, survivors often raise multiple concerns during their therapy sessions. CT-TRG is a very focused, systematic approach for dealing with a highly specific set of problems, and sometimes it is a challenge to keep clients from interrupting the process by getting off-task or bringing up other problems. One way of maintaining the therapeutic focus is to gain upfront agreement from a client that the sole agenda for a session (or series of sessions) will be guilt. Of course, in residential or intensive PTSD treatment programs, it may be practical to include a separate guilt management module as part of a multimodal treatment program.

An off-the-topic issue that comes up frequently in the course of CT-TRG is trauma-related anger. As clients talk about their guilt and their role in the trauma, they sometimes switch the subject and express anger toward someone else about their role in the trauma. For example, when discussing trauma-related guilt, it is not uncommon for incest survivors to precipitously shift the discussion to their anger about being exploited or betrayed or bemoan "why" someone was not there to protect them (e.g., "Why didn't my mother stop the abuse?"). In my experience, clients who have suffered the sudden and untimely loss of loved ones are particularly prone to raise anger issues in the course of addressing their guilt. For example, one client whose wife inexplicably murdered their two small children flip-flopped back and forth between his own guilt and his anger toward his wife, her parents, the police, and the social worker who had not detected his wife's mental illness. When anger issues emerge in the course of CT-TRG, I typically highlight the distinction between guilt and anger and advise clients how I would like to proceed. For example, I may say:

> "Remember, guilt is an unpleasant feeling with associated beliefs about what one should have done differently. Anger is the same unpleasant feeling with associated beliefs about what *someone else* should have done differently. This explains why a person can so easily shift back and forth between guilt and anger. However, we can't treat guilt issues and anger issues at the same time. Let's concentrate on your guilt now. Later, I will help you deal with your anger."

IS CHRONIC GUILT EVER AN "APPROPRIATE" REACTION AND IMPROPER TO TREAT?

It has been suggested that guilt may sometimes be an "appropriate" reaction (as in cases of perpetration, either in war or associated with a history of abuse). It is thought that such guilt may be functional insofar as it leads to prosocial behavior and that treatment of this "appropriate" guilt may be improper, if not unethical. These viewpoints raise a hornet's nest of issues that could easily be the topic of an entire article. Below, I briefly highlight several factors that need to be taken into consideration when examining this complex issue.

First, *transitory* guilt that emerges in the course of everyday life events may often be functional or adaptive because guilt stimulates reparative actions that restore the equilibrium in social relationships (Baumeister, Stillwell, & Heatherton, 1994). However, impulses to make restitution are often thwarted after traumatic events that have irreparable consequences (e.g., death, permanent injuries), and there is little evidence that chronic, trauma-related guilt is adaptive, particularly when it is severe. In fact, there is considerable evidence that trauma-related guilt is very maladaptive. For example, studies cited earlier have found trauma-related guilt to be highly positively correlated with PTSD, depression, negative self-esteem, social anxiety and avoidance, and suicidal ideation. In addition, we have unpublished data that indicate that trauma-related guilt is positively correlated with "hostile ruminations," "desire for drugs or alcohol," "death-wish ruminations," and "isolative depression" (Kubany, 1997d). In many instances, trauma-related guilt may actually be associated with elevations in *dysfunctional* behavior rather than elevations in *prosocial* behavior. Because traumatic events are often considered irreparable and can be extremely painful to remember, *avoidance* reactions may be far more common than *reparative* actions. For example, in structured interviews of the phenemonology of trauma-related guilt with 18 Vietnam War veterans, the most common response to the question, "What do you *do* when you feel guilty about what happened?" was to become socially isolative (Kubany et al., 1996). None of the respondents mentioned efforts to make restitution.

Second, some believe guilt is an appropriate reaction that keeps hostile or antisocial impulses in check. Concerns about whether or not to treat "appropriate" guilt are often predicated on the *assumption* that if someone no longer feels guilty about a perceived transgression, an important social control mechanism—which guilt is presumed to maintain—will collapse. However, there is no *empirical evidence* that alleviation of guilt is associated with a disinhibition of antisocial inclinations (nor has this ever been evidenced in my experience working with many combat veterans and numerous abused women who had also been abusive [e.g., with their children]).

Third, perpetrators whom most people might agree should feel guilty (e.g., rapists, child molesters, batterers, murderers) *do not experience guilt* because they

do not get upset when they think about what happened or because they blame their victims instead of themselves. However, it may not be an absence of guilt about *prior* transgressions that causes perpetrators to transgress again, but rather *current deficits* in the capacity to experience empathy. Many professionals emphasize the importance of teaching criminal offenders to experience "anticipatory" *empathetic distress* as a *deterrent to subsequent transgressions* (e.g., to feel badly for a little girl when contemplating molestation rather than to experience sexual arousal [Marshall, Hudson, Jones, & Fernandez, 1995]).

Fourth, when a person believes that someone else deserves to feel guilty, that person casts him- or herself in the role of judge. To express the value that guilt is an appropriate reaction implies that the guilty party should experience *distress* when he or she thinks about what happened (a *necessary* condition for guilt to occur). When this value judgment is made, the question must be asked, "*How badly* should the person feel and for *how long*?" For a perpetrator to continue to experience guilt may be "appropriate" from a societal viewpoint or be functional or serve a useful purpose for the victim (who may want the perpetrator to suffer). However, it may not be in the best interests of or adaptive for the perpetrator to remain guilt-ridden.

In many situations, the real question may not be, "Can perpetrators who feel guilty be taught to experience less guilt?" but rather, "Would clinicians be willing to treat such guilt?" To illustrate, I will give an example of a woman who committed a terrible crime. A couple of years ago, a young South Carolina mother, Susan Smith, murdered her two sons by allowing a car with the boys inside to roll into a lake. I suspect that Ms. Smith could be taught to experience less guilt (*assuming* she feels guilty about what she did) but that many clinicians might be reluctant to treat her guilt because they do not think she deserves treatment.

Fifth, I argued in an earlier article that

> there is a big difference between the belief that "I should have behaved differently" and the belief that "If I had it to do over again and knowing and believing what I do now, I would behave differently." One does not have to feel guilty to have learned from the past and to make enlightened future choices. . . . In addition, it may be all too easy for outsiders to self-righteously pass judgment without fully appreciating the totality of historical and circumstantial forces acting on individuals caught up in a maelstrom of traumatic events. . . . (Kubany, 1994, p. 14)[1]

As a final point, the guilt-related beliefs of the vast majority of trauma survivors with whom I have worked over the years have been so *irrational* that

[1]Some readers may be interested in reading about how I addressed a Vietnam veteran's guilt about going against his "personal moral and religious convictions by taking human lives" and about "mutilating enemy dead and taking body parts (ears) as war souvenirs" (Kubany, 1997c).

the ethics of treatment has virtually never been a consideration. However, the issues surrounding the topic of "appropriate" guilt and the conditions under which guilt should be considered adaptive or maladaptive are extremely complex. This important topic certainly merits further discussion and empirical study.

EVALUATION OF TREATMENT AND FUTURE DIRECTIONS

The specific objectives of CT-TRG are very precise and easily measured. For each guilt issue addressed, the objective is to help clients achieve an objective appraisal of their role in the event—in terms of their beliefs about preoutcome knowledge, justification, responsibility, and wrongdoing. Assessing and reassessing these beliefs is an integral part of the process of CT-TRG—as measured by clients' answers to repeatedly asked questions (e.g., "Now how responsible do you think you were for causing . . . ?") and their responses on administrations and readministrations of the AAGS. Thus, therapists practicing CT-TRG will know whether they are making progress toward the specific objectives of CT-TRG as therapy proceeds.

Of course, the broader objectives of CT-TRG—in the larger context of cognitive-behavioral therapy with trauma survivors—are to ameliorate suffering and symptoms of PTSD and posttrauma depression. At present, evidence for the efficacy of CT-TRG is based on client self-reports and client responses on assessment questionnaires administered before and after therapy. Based on my pre-post therapy assessments with individual clients, CT-TRG appears to ameliorate symptoms of PTSD, depression, and negative self-esteem as well as guilt (e.g., Kubany, 1997c). Nonetheless, CT-TRG needs to be evaluated in controlled research before any general claims can be made regarding its efficacy. With that said, the procedures of CT-TRG are firmly grounded in cognitive-behavioral theory and rest on principles that are well established in empirical research.

Importantly, the procedures of CT-TRG are still being refined and elaborated. For example, we have only recently incorporated the systematic use of self-monitoring exercises into the practice of CT-TRG. In addition, we have been developing a cognitive therapy approach for addressing trauma-related anger, which complements CT-TRG. We are also developing a treatment manual and intend to conduct numerous studies to establish the efficacy of CT-TRG—starting with single-subject, multiple baseline, and quasi-experimental designs, culminating eventually in controlled clinical trials.

APPENDIX: Attitudes About Guilt Survey (AAGS; Version All)[2]

Individuals who have experienced traumatic events often experience guilt which is related to these events. They may feel guilty about something they did (or did not do), about beliefs or thoughts that they had (that they now believe to be untrue), or about having had certain feelings (or lack of feelings).

Please take a moment to think about your experience. Briefly describe what happened and what you feel guilty about:

_____

_____

_____

In answering each of the following questions, please circle ONE letter that best reflects or summarizes your view of what happened.

1. To what extent do you think that you should have known better and could have prevented or avoided the outcome?
   a. There is no possible way that I could have known better.
   b. I believe slightly that I should have known better.
   c. I believe moderately that I should have known better.
   d. For the most part I believe that I should have known better.
   e. I absolutely should have known better.

2. How justified was what you did? (i.e., How good were your reasons for what you did?)
   a. What I did was completely justified.
   b. What I did was mostly justified.
   c. What I did was moderately justified.
   d. What I did was slightly justified.
   e. What I did was not justified in any way.

3. How personally responsible were you for causing what happened?
   a. I was in no way responsible for causing what happened.
   b. I was slightly responsible for causing what happened.
   c. I was moderately responsible for causing what happened.
   d. I was largely responsible for causing what happened.
   e. I was completely responsible for causing what happened.

   Your percentage of responsibility _____%

[2] Adapted slightly from Kubany and Manke (1995).

4. Did you do something wrong? (i.e., Did you violate personal standards of right and wrong by what you did?)
   a. What I did was extremely wrong.
   b. What I did was very wrong.
   c. What I did was moderately wrong
   d. What I did was slightly wrong.
   e. What I did was not wrong in any way.

5. How distressed do you feel when you think about what happened?
   a. I feel no distress when I think about what happened.
   b. I feel slightly distressed when I think about what happened.
   c. I feel moderately distressed when I think about what happened.
   d. I feel very distressed when I think about what happened.
   e. I feel extremely distressed when I think about what happened.

6. Circle the answer which indicates how often you experience guilt that relates to what happened.

   Never Seldom Occasionally Often Always

7. Circle the answer which indicates the intensity or severity of guilt that you typically experience about what happened.

   None Slight Moderate Considerable Extreme

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